Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

If you would like to prescribe a Preferred Drug, Please do so in the space provided and **FAX form back to the dispensing pharmacy**. Otherwise, continue with the Prior Authorization process by completing the rest of this form & FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka)	**Rx** _____ Physician signature _____ Date

This includes all generic equivalents

DRUGS for MIGRAINES - Triptans

Preferred Drug Covered *This includes all generic equivalents*			**Non-preferred Prior Authorization Required** *This includes all generic equivalents*		
Almotriptan	Axert®		Frovatriptan	Frova®	
Eletriptan	Relpax®				
Rizatriptan	Maxalt®	Maxalt-MLT®	Naratriptan	Amerge®	
Sumatriptan	Imitrex®		Zolmitriptan	Zomig®	Zomig-ZMT®

** **Indicates REQUIRED information**

****CONSUMER NAME:** _____ **Medicaid Number:_____

****PHARMACY NAME:** _____ **Medicaid Number:_____

**Phone Number:_____ **Fax Number:_____ **NDC:_____

****PRESCRIBING PHYSICIAN NAME:** _____ **Medicaid Number:_____

**Phone Number:_____ **Fax Number:_____

** ***Indicate:*** Non-Preferred Drug prescribed: _____ Other:_____

** ***Check:*** the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:

☐ Medical intolerance to Preferred Drug. **Provide clinical symptoms**:_____

_____

☐ Inadequate response to Preferred Drug.

** ***Indicate:*** Preferred Drug tried: _____ Length of trial: _____

☐ Absence of appropriate formulation or indication of the drug. Please specify:_____

_____

**Prescribing Physician's signature: _____ Date: _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593.

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